

G.I. Associates of West Alabama, P.C.

Patient Information Physician Date

Social Security Number (Required) Referring Physician
Sex Male Female
Name Last First MI
Street Address
City State Zip
Mailing Address (include only if different from street address)
Date of Birth (MM/DD/YYYY)
Home Phone Work Phone Cell Phone
E-mail Address
Marital Status Single Married Divorced Widowed
Employer Address
Spouse Spouse's Date of Birth (MM/DD/YYYY)
Spouse Employer Spouse Work Phone

If the patient is a minor, please list responsible party
Relationship Date of Birth Phone
Address

AUTHORIZATION FOR TREATMENT/PAYMENT - I authorize G.I. Associates of West Alabama, P.C. to provide medical treatment and hereby agree to pay any outstanding balance whether paid for or denied by my insurance company or third party payer.

AUTHORIZATION TO RELEASE INFORMATION - I authorize the Physician to release any information required, in the course of my exam or treatment, to my insurance company or any third party with whom I have coverage. Furthermore, I authorize any holder of medical information about me to release said medical information to a physician or other medical professional who may be a part of my care.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN - If I have Insurance, Medicare, Medicaid, or Workman's Compensation, I authorize payment directly to the physician for medical services rendered. I understand that G.I. Associates of West Alabama, P.C. will file insurance claims to my primary and/or secondary insurance carrier. G.I. Associates of West Alabama, P.C. does not currently file with a third payer.

COPAYS, DEDUCTIBLES, AND NON-COVERED CHARGES - I understand that I am responsible for any unpaid balance, co-pays, deductibles, and non-covered charges relating to my care, and that co-pays and deductibles are due at the time of the service. I acknowledge that any co-pays and/or deductibles must be paid before any procedure can be scheduled. Accounts having a balance over 30 days old are considered delinquent, and I understand if my bill goes to collection, that in addition to the account balance, I will also be liable for any court costs and/or attorney fees involved in collecting the delinquent bill.

APPOINTMENT CANCELLATION - Except in the case of verifiable emergencies, failure to give a 24 hour notice of cancellation of an appointment will result in a "no show" charge of \$50 to my account, and failure to give a 48 hour notice of cancellation for outpatient procedures may result in a \$100 charge to my account. These charges cannot be billed to my insurance company and are my responsibility. Failure to pay fees will be treated according to policy as a unpaid balance. While care will not be withheld for medical emergencies, three consecutive "no show" occurrences can result in discharge from the practice.

PATIENT SIGNATURE DATE

G.I. Associates of West Alabama, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IS CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used a necessary to support the day-to-day activities and management of G.I. Associates of West Alabama, P.C. For example, information on services you received may be used to support budgeting and financial report, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspection, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of you health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders. We also use an automated telephone appointment reminder system that will leave a message on your answering machine. If you do NOT want notices sent to your home or messages left on an answering machine, please notify the receptionist.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that may find to be of interest. We may also send you information describing other health-related goods and service.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive and accounting pf of how to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

G. I. Associates of West Alabama, P.C. Duties

We are required by law to maintain the privacy of your health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices policies and practices that are outlined in this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contracting the Receptionist or the Office Manager.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concern to:

Compliance Officer
G.I. Associates of West Alabama, P.C.
1774 McFarland Blvd. North
Tuscaloosa, AL 35406

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Compliance Officer
G.I. Associates of West Alabama, P.C.
1774 McFarland Blvd. North
Tuscaloosa, AL 35406

Effective Date

This Notice is effective on or after October 1, 2002.

Acknowledgement of Receipt

I have reviewed and understand G.I. Associates of West Alabama's Privacy Notice.

Patient Signature

Date

G.I. ASSOCIATES OF WEST ALABAMA, P.C.

PERMISSION TO RELEASE INFORMATION

It is a breach of patient confidentiality for a physician and/or their staff to release any information regarding you or your medical condition to anyone without your permission. This includes your medical condition, prognosis, appointment times, insurance information, billing and demographic information. Therefore, if you anticipate the need for anyone else to have access to this information, please complete the information below.

I (we), the undersigned patient and/or responsible part, hereby authorize G.I. Associates of West Alabama, P.C., its physicians, agents, employees, or representatives to discuss or release any or all patient information, billing information, appointment scheduling, prescriptions, etc., to the person or personal indicated below.

_____ Spouse Name _____

_____ Parents Name _____

_____ Children Names _____

_____ Other	Relationship	Name

Patient Signature

_____/_____/_____
Date